THERAPIST/COUNSELOR REPORT

Report Due: Monthly for the first 6 months of full compliance and then quarterly thereafter.

DOPL
ATTN: COMPLIANCE UNIT
PO BOX 146741
SALT LAKE CITY UT 84114-6741

Case #: _____

Name of Licensee: _____

Profession _____

Dates Seen:_____

Length of Sessions:_____

Were there any missed appointments?
❑ No ❑ Yes How many?_____

Questions? Call 530-6428, 530-6718 or 530-6295

Have you read the conditions of licensee's Contract/Order? ❑ Yes ❑ No. *If No, please read it before submitting this document.*

Diagnosis (DSM-4 Axis I-V) _____

_____

Please list current medications:_____

_____

What are the major issues being addressed in therapy?_____

_____

Please list the goals of treatment:_____

_____

Please comment in detail on how the licensee is doing with regard to relevant issues. Include at least the following: recognition and insight into problems, interaction during sessions, ability to solve problems and compliance with recommendations. _____

_____

_____

_____

Evaluation of Progress_____

_____

_____

Is Licensee in Compliance with Treatment Plan? ❑ Yes ❑ No

In your opinion, is Licensee safe to Practice? ❑ Yes ❑ No

_____
Name (*Please Print*)

_____
Signature of Therapist

_____
Title (*Please Print*)

___/___/___
Signature Date

This document may be submitted by FAX to (801) 530-6404.